

LARGE GROUP DENTAL ENROLLMENT / CHANGE APPLICATION

Part 1888-558-9212 New Applicant Change of Coverage Part Ime to Full- Dept/EE Number Pronon: 1-877-983-3582 Late Eurollee Name/Address Change Ime Ime Date of Birth Make Make Pronon: 1-877-983-3582 Late Eurollee Name/Address Change Ime Ime Ime Date of Birth Make Pronon: 1-877-983-3582 Late Eurollee Name/Address Change Ime	Social Security No		o. Group Number					Effec	Effective Date	
Plone: LST7:983-3552	TeamService@deltadentalia.com									
Late Enrolle	11187 4 80		Change of Cov		overage	verage		Full- Dept/EE Number		
Name (First, Middle Initial, Last)			8 9 -							
Complete Address – Street City State Zip Status Disiple (EMarried Hire Date Control (specify)	- Similar Company of the Company of	Middle Initial, Last)			Telephone		Date	of Birth	☐ Male	
Cother (specify)	SECTION I			and the same of th	()				☐ Female	
Missas check the coverage you are applying for:	Complete Address - Street	City	State Zip		Status	Status 🗆 Single 🗆 Mar		Hire Date		
Employee/Child(ren) Employee/Sposse/Child(ren) Employee/Sposse/Child					☐ Other (specify)		·	//		
DEmployee/Child(ren) Demployee/Spouse/Child(ren) Demployee/Spouse/Child(ren) Torthieve my Explanation of Benefits (EOB's) from the Delta Dental of Iowa's subscriber connection website @ www.tetradentalia.com. E-Mail: Signature:	Employer Name & Location			Please check the coverage you are			re applyin	ıg for:		
Tauthorize Delta Dental of Iowa to notify me via e-mail to retrieve my Explanation of Benefits (EOB's) from the Delta Dental of Iowa's subscriber connection website @ www.deltadentalia.com. E-Mail: SECTION II										
Signature: SECTION II ELIGIBLE DEPENDENTS										
SECTION II ELIGIBLE DEPENDENTS										
SECTION II ELIGIBLE DEPENDENTS Scient										
Social Security Number Birthdate Sex Sull-Time College Disabled Status Coverage Disabled Status Coverage Disabled	Digitature:								,,	
First Name Middle Initial Last (if different) Number Birthdate Sex College Dental Coverage Disabled Dental Coverage Disabled Disable	and the first of the second	SECTION	III EL	IGIBLE	DEPENDE	NTS	•			
First Name Middle Initial Last (if different) Number	List eligible members of your fam	ily to be covered	S	ocial	***************************************	I	Full-Time	;	į.	
Spouse	British Riama Reidelle W. 141 H	V and (16 31660 ward)	2		Birthda	te Sex	, –	1	5	
Eligible Child	Market and the second s	Last (ii dinerent)	Nu	mber		$ \frac{1}{2}$ $\frac{1}{2}$	Student		10	
Eligible Child	Spouse				_/_/	§		1	E3140	
Eligible Child	Eligible Child						DVec DN			
Eligible Child	Difficio Onita							ł	1	
Eligible Child								Disable		
Eligible Child	Eligible Child				/ /	1	8	'	LINO	
Eligible Child						- U F	SCHOOL NAME	. 1103	LIYes	
Eligible Child	Eligible Child				, ,	Ом		' [.	!? □No	
Eligible Child			one of the state o			- O F	School Name	: DYes	□Yes	
Eligible Child	Eligible Child	<u></u>				Пи	ΠVes ΠNo	Disabled	? TNo	
Cother Dental Coverage - If any person(s) on this application has dental insurance through another company where the employer pays any portion of the cost or makes payroll deductions, please complete: Contract holder: Name of other dental carrier Policy Number Effective Date Contract type								8	8	
Other Dental Coverage - If any person(s) on this application has dental insurance through another company where the employer pays any portion of the cost or makes payroll deductions, please complete: Contract holder: Name of other dental carrier	D1. 11 OL11							Disabled		
Other Dental Coverage - If any person(s) on this application has dental insurance through another company where the employer pays any portion of the cost or makes payroll deductions, please complete: Contract holder: Name of other dental carrier	Eligible Child				/ /	3 1		1	LINO	
pays any portion of the cost or makes payroll deductions, please complete: Contract holder:						- U F	School Name.	L 103	LIYes	
Name of other dental carrier Policy Number Effective Date Contract type SECTION III CHANGE OF COVERAGE Please check events requiring Contract changes: Marriage Death Divorce Birth/Adoption Drop Spouse/Child(ren) COBRA Terminating Benefits Name of Affected Party Date of Event SECTION IV AGREEMENT and CERTIFICATION Thave read and understand the Agreement and Certification and/or Waiver of Coverage language on the back of this application and acknowledge receipt of a fully completed copy of this application. ACCEPTANCE OF COVERAGE I waive dental coverage for my dependents and myself. (Please indicate reason) I (We) have coverage under another dental plan. I (We) do not wish to enroll	Other Dental Coverage - If any person(s) on this application has dental insurance through another company where the employer									
Name of other dental carrier Policy Number Effective Date Contract type	pays any portion of the cost or ma	ikes payroll deduction	is, please c	omplete:	Contract h	older:				
SECTION III CHANGE OF COVERAGE Please check events requiring Contract changes: Marriage			7 8 4 C			703.6	<u> </u>			
Please check events requiring Contract changes: Marriage Death Divorce Birth/Adoption Drop Spouse/Child(ren) COBRA Terminating Benefits Name of Affected Party Date of Event SECTION IV AGREEMENT and CERTIFICATION Thave read and understand the Agreement and Certification and/or Waiver of Coverage language on the back of this application and acknowledge receipt of a fully completed copy of this application. ACCEPTANCE OF COVERAGE WAIVER OF COVERAGE I waive dental coverage for my dependents and myself. (Please indicate reason) I (We) have coverage under another dental plan. I (We) do not wish to enroll	Name of other dental carrier			***************************************			tective Date	e Cor	itract type	
Marriage Death Divorce Birth/Adoption Drop Spouse/Child(ren) COBRA Terminating Benefits Other (explain) Name of Affected Party Date of Event SECTION IV AGREEMENT and CERTIFICATION Thave read and understand the Agreement and Certification and/or Waiver of Coverage language on the back of this application and acknowledge receipt of a fully completed copy of this application. ACCEPTANCE OF COVERAGE WAIVER OF COVERAGE I waive dental coverage for my dependents and myself. (Please indicate reason) I (We) have coverage under another dental plan. I (We) do not wish to enroll		SECTION I	II CH	ANGE C)F COVERA	AGE				
Other (explain) Name of Affected Party Date of Event SECTION IV AGREEMENT and CERTIFICATION have read and understand the Agreement and Certification and/or Waiver of Coverage language on the back of this application and acknowledge receipt of a fully completed copy of this application. ACCEPTANCE OF COVERAGE I waive dental coverage for my dependents and myself. (Please indicate reason) I (We) have coverage under another dental plan. I (We) do not wish to enroll										
SECTION IV AGREEMENT and CERTIFICATION have read and understand the Agreement and Certification and/or Waiver of Coverage language on the back of this application and acknowledge receipt of a fully completed copy of this application. ACCEPTANCE OF COVERAGE I waive dental coverage for my dependents and myself. (Please indicate reason) I (We) have coverage under another dental plan. I (We) do not wish to enroll	☐ Marriage ☐ Death ☐ Divorce ☐ Birth/Adoption ☐ Drop Spouse/Child(ren) ☐ COBRA ☐ Terminating Benefits									
have read and understand the Agreement and Certification and/or Waiver of Coverage language on the back of this application and acknowledge receipt of a fully completed copy of this application. ACCEPTANCE OF COVERAGE I waive dental coverage for my dependents and myself. (Please indicate reason) I (We) have coverage under another dental plan. I (We) do not wish to enroll	Other (explain)		Vame of At	ffected Pa	arty		Date	of Event_		
ACCEPTANCE OF COVERAGE I waive dental coverage for my dependents and myself. (Please indicate reason) I (We) have coverage under another dental plan. I (We) do not wish to enroll	SECTION IV AGREEMENT and CERTIFICATION									
ACCEPTANCE OF COVERAGE I waive dental coverage for my dependents and myself. (Please indicate reason) I (We) have coverage under another dental plan. I (We) do not wish to enroll	have read and understand the Ac	reamont and Cartifics	ation and/o	r Waiver	of Coverage	language	on the back o	of this anni	ication and	
ACCEPTANCE OF COVERAGE I waive dental coverage for my dependents and myself. (Please indicate reason) I (We) have coverage under another dental plan. I (We) do not wish to enroll				i AA GIIA CI	or coverage	ianguage (ou the back (vi civio albhi	ivation and	
☐ I waive dental coverage for my dependents and myself. (Please indicate reason) ☐ I (We) have coverage under another dental plan. ☐ I (We) do not wish to enroll /// Explana Signature										
(Please indicate reason) □ I (We) have coverage under another dental plan. □ I (We) do not wish to enroll	☐ I waive dental coverage for my dependents and myself.									
☐ I (We) do not wish to enroll /// Freelows Signature Deta				(Plea	ase indicate r	eason)	-		STATIONALIA	
Total Posts										
Employee Signature Date Employee Signature Date					(We) do not	wish to en	roll		esservices	
Employee Signature Date Employee Signature Date		,								
	Employee Signature	Signature Date			Employee Signature D					